APPENDIX H

EVALUATION OF THE PROJECT BY THE PROJECT TEAM

On April 27th 2012, the project team assembled to reflect on the project and think about what worked and what didn't work about the project. We also asked why some things had worked and some had not - as lessons for future projects.

WHAT HAS WORKED?	WHY DO WE THINK IT WORKED?
Strengthening individual commissioning We added value to the work of some SWs who spontaneously expressed appreciation. Although they were hard to get hold of, care managers were prepared to reflect on their work and think through what needed to happen. This seemed to be well received by the care managers who we were able to engage	Their cases were at the right point of needing the project's input i.e. the worker was already planning change or there was a clear need for change die to risks. The workers appeared to be particularly open to learning and they wanted to improve their practice. We possibly talked about areas they had not considered or that they had dismissed. For some workers, new generic team management means their line manager does not necessarily have knowledge/experience around complex needs so the project seemed particularly useful
Improving knowledge of positive behavioural support All workers who spent time talking to or liaising with the Behaviour Consultant found this interesting and useful	One piece of consultancy about someone in an OOA placement enabled the SW and family to see it was not adding value so it could be brought to an early end. The placement cost twice what the future supported living service will cost with the person returning to his family's local community instead of living over 80 miles away. One area has chosen to commission more input which also may be due to learning from campus reprovision where the only advice available to the commissioners was from providers, both incoming and outgoing
Improving Housing Options Housing advisor visited some people's families to talk about supported living. The visits were well received by families	One family moved on particularly significantly in their thinking about what options there could be for their relative as an alternative to residential care. He was impartial and not linked to LA or NHS. They probably found his expertise reassuring
Developing Provider Knowledge The provider workshop in one area was well received by attendees. This was a presentation on the work of the CBF, the project, housing related policy and the theory of positive behavioural support	The project team prepared well and considered the audience's perspective. The audience appeared to like the free expertise on offer - they see CB as a growth area. We had been told to expect 28-30 people as attendance is optional yet there were over 50

WHAT HAS WORKED?	WHY DO WE THINK IT WORKED?
Multi-Agency/Generational Commissioning The initial inter-agency project set-up meeting in one area stimulated useful discussion. There were representatives from children's services, continuing healthcare, specialist healthcare services, someone reviewing healthcare services, adult care, specialist teams. Everyone could think of at least one case which was 'stuck' and the need for help with it	Meeting attendees saw how each other was involved in the CB pathway and there was a sense that they did not appear to know each other well or communicate systematically: the enthusiasm in the meeting promised to improve collaborative working such as shaping the market

WHAT HAS NOT WORKED?	WHY DO WE THINK THIS IS SO?
Local Ownership The project design relied on a local lead role to drive local progress and engage between local leads meetings in e.g email discussion or attending events such as the DH review or other forums	The project started at a time when public sector spending cuts were about to impact, with huge organisational change being implemented and uncertainties in staff structures. Local leads did not appear to have time to work on getting the best possible impact from the project. One asked us to convey to their senior managers that they needed to understand operational pressures and not agree to initiatives for which there is no capacity. For 6 months, another said they were only 'holding' the role until someone was nominated. That 'someone' was nominated in January 12 though they were only in role until the end of March 12. They had no working links with the NHS, no mainstream role and access to only 1 care manager.
Getting on with the project People were nominated either very slowly or not at all. Took a long time to get nominations and we had to expend a lot of effort to get them	Area 1's local lead manager was off sick, delaying nominations. The person who nominated Area 2's people had no operational link to care management. Area 3 only managed to enable one worker to participate out of a possible five. Area 4 did not appear to have any way of identifying the people and SWs to participate and had no dialogue with the NHS. Area 5 was keen to participate though took a long time to decide which officer would engage with the project
Outcome-focussed plan – a person-centred plan was assumed as the starting point for each person	We were not tasked or resourced to provide support with person-centred planning as it was assumed that previous investment in this would have matured into embedded practice. However, the lack of person-centred plans - ambitious or otherwise - were a barrier for many people either in terms of timeliness or altogether

WHAT HAS NOT WORKED?	WHY DO WE THINK THIS IS SO?
Developing individual plans There has been very slow progress on developing plans. None are complete	Several workers regarded person centred planning as something only PCP co-ordinators could do and were not proactive in setting this in train. The other observation is that unless there are immediate risks making a person's life unsafe in some way, proactive planning is not a service priority. We only observed proactive planning for two people. For four others, planning has been good but stretched over time, so though change is being actively planned, their situations have not changed quickly. Some SWs engaged only superficially. Two opted out entirely. Some did not have time due to major changes in team and management structures. Others said other work was more urgent (safeguarding; DOLs; best interests decisions) or they just had too much to do
Wider impact of learning We were not able to set up action –learning sets or explore of issues	People said they did not have the time to participate in action learning sets. We did not get responses to questions presented as email discussions; a well-designed commissioning workshop for one LA was poorly attended. People arrived late for meetings and left early. Difficult to plan phone calls
Support at the right time A lack of or slow person centred support planning processes meant there was a lack of stated sought outcomes for people which we could help realise through advising on the commissioning process	There was not enough resource to offer local consultancy for the full development of a plan so the focus was on advising on how to achieve the identified outcomes of a PCP e.g. "a home of my own". On reflection, it might be been better for consultants to get involved earlier to encourage more ambition from the outset. However, there would then have been insufficient consultancy resource to then support workers to realise the ambitions. We tried to manage the resource across areas so if one area needed more PBS and another more housing advice, this would balance out. An alternative would have been to allocate a time budget of each consultancy to each person to be used or not
Housing outcomes Project came out of the regional housing agenda, but housing advice was not the priority need in the cases identified. and for others it was direct work to help to engage troubled families	People who signed up for the project moved to other jobs or retired when the project started. Perhaps they did not brief those who took it forward re the housing objective so several nominations to the project did not reflect this 1. Some families did not agree with supported living and needed skilful family intervention to work towards a more open attitude 2. Others needed more general skilful direct work with their family which we were not resourced or intended to offer 3. Some people put forward were in a care home yet no move was wanted by the workers or the families 4. One local authority worker was keen to use a residential care model and was supported by the NHS commissioner in this
Contributing to Joint Strategic Needs Assessment Not aware whether this happened at all	Local leads did not wish to engage in discussion about this in meetings or by email. When asked to confirm that they would make the necessary local links they affirmed that this would happen, but they did not answer a question about how it would happen